

DEPARTMENT OF VETERANS AFFAIRS ILLIANA HEALTH CARE SYSTEM
1900 East Main Street
Danville, IL 61832

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INFECTION CONTROL PROGRAM AND PLAN

- I. **PURPOSE:** The mission of the Infection Control Program is to promote a healthful environment for the Veterans we serve, and for our healthcare providers. We seek to identify and eliminate factors that could contribute to the development of infections. Should significant instances of infections occur, interventions are planned and implemented to prevent healthcare acquired infections in Veterans and to safeguard the health of staff. An interdisciplinary committee will be established. The plan will define the surveillance program and plan for prevention, and control of infections, and communicate findings to other health care workers.

- II. **POLICY:** To support and promote an effective Infection Control Program within the Medical Center and community based outpatient clinics. It encompasses both patient care and employee health services. Surveillance activities are appropriate to our Veteran population and are based on the annual Infection Control Risk Assessment. Centers for Disease Control (CDC) and National Health Safety Network (NHSN) definitions for surveillance are used. The Multidrug Resistant Organism (MDRO) Prevention Coordinator works in conjunction with the Infection Control Coordinator and manages the MDRO Prevention Initiative per the MDRO Prevention Initiative VHA National Program Office Guidelines (See Attachment A). Pertinent findings from both programs are reported to the Infection Control Committee whose recommendations are presented to the Clinical Executive Board for approval and action. The Infection Control Committee, in conjunction with the Infection Control Coordinator, oversees the development and implementation of facility and departmental measures to prevent, identify, and control healthcare associated infections and community acquired infections in our Veteran and staff populations. It is our policy to use evidence based national guidelines based on current scientific knowledge, applicable laws and regulations and follow Centers for Disease Control (CDC) and/or Association for Professionals in Infection Control (APIC) guidelines to guide policy development.

- III. **AUTHORITY:** The Chief of Staff has oversight of the Infection Control Program. The Infection Control Coordinator has the clinical authority and direct responsibility of the infection prevention and control program and is responsible for 1) developing policies governing control of infections and communicable diseases, 2) implementing policies governing control of infections and

communicable diseases, and 3) developing a system for identifying, reporting, investigating and controlling infections and communicable diseases. The Infection Control Coordinator shall have the authority to institute appropriate control measures or studies when there is believed to be potential danger to Veterans or personnel. Such action will be accomplished with the knowledge of the physician(s) and service chief(s) involved, when feasible. Decisions regarding the disposition of individual Veterans, which may be contrary to the wishes of the attending physician(s), shall be referred to the Chief of Staff. In addition, voting on recommendations in the Infection Control Committee of a clinical nature will be limited to clinical professional members. The Infection Control Committee has the authority for the Infection Control Program.

IV. PROCEDURE:

- A. The Microbiology Department notifies the Infection Control Coordinator of significant findings, i.e., AFB positive sputum specimens, instances of multidrug resistant organisms, C-Difficile, positive blood cultures, Legionella and unusual pathogens.
- B. The Infection Control Coordinator reviews Veterans' records, discusses concerns with ward personnel, and may make recommendations regarding the need for infectious disease consults, the need for isolation and/or entering the order. The Infection Control Coordinator may also order follow up lab cultures as appropriate.
- C. The Infection Control Coordinator is given the authority to provide information (reports) to local and state health departments as required by law, and to prepare HIV/AIDS reports for VACO and other agencies. The Infection Control Coordinator may consult with the Chairman of Infection Control Committee regarding administrative and other complex procedural matters.
- D. The Infection Control Coordinator, Registered Nurse, or Medical Professional may get verbal consent for HIV testing and document the consent. The Infection Control Coordinator may order HIV/Hepatitis diagnostic labs when indicated. HIV/AIDS Veterans are followed in Infectious Disease Clinic. The Infection Control Coordinator coordinates referrals to ID Clinics at other facilities as needed.
- E. The Occupational Health Nurse and Infection Control Coordinator collaborate on issues of employee health, i.e., needle stick injuries, hepatitis B vaccine program, PPD testing, and scabies management. The Infection Control Coordinator or designee obtains the HIV verbal consent and orders HIV and hepatitis testing for the source patient after a bloodborne pathogen exposure.

- F. The Infection Control Coordinator develops surveillance objectives annually, based on assessment of the risks of infection among our Veteran population. These objectives are presented to the Infection Control Committee for approval and are evaluated for evidence of improved patient care.
- G. In addition, special studies may be conducted that include:
 - 1. Investigation of clusters of infections above expected levels.
 - 2. Investigation of single cases of unusual or epidemiologically significant healthcare acquired infection, (example: nosocomial group A strep bacteremia).
- H. Service policies are reviewed every three years by the Infection Control Committee. The Infection Control Coordinator serves as a consultant to service chiefs in preparing policy updates and educational programs.
- I. Annual infection control education is the responsibility of the service chiefs, who may consult with the Infection Control Coordinator. The Infection Control Coordinator may assist with programs, as requested. The Infection Control staff participates in New Employee Orientation.
- J. Joint Commission (JC) Surveillance, Prevention, and Control of Infection Function outline is attached and guides the surveillance process. (Attachment C).

V. MEMBERSHIP INFECTION CONTROL COMMITTEE:

At a minimum:

- A. Physician, Chairperson
- B. Infection Control Coordinator, Co-Chair
- C. Infectious Disease Physician Consultant
- D. Microbiology
- E. Occupational Health Nurse (OHN)
- F. MDRO Coordinator
- G. Patient Safety Representative
- H. Representatives from:
 - 1. Administration
 - 2. Environmental Safety
 - 3. Nursing
 - 4. SPS
 - 5. EMS
 - 6. Engineering
 - 7. Surgery
 - 8. Medicine/Hepatitis C Coordinator

9. Mental Health
10. Dental
11. Pharmacy
12. AFGE
13. G&ECS
14. PICC/CL RN
15. Home Based Primary Care

VI. RESPONSIBILITY OF INFECTION CONTROL COMMITTEE:

I. The Committee:

1. Approves the type and scope of surveillance activities, as well as approving actions to prevent or control infections.
2. Reports to the Director through various leadership committees, Clinical Executive Board and Environment of Care Committee, to ensure compliance with the Infection Control Program.
3. Reviews, and approves every three years, all clinical service policies related to infection surveillance, prevention, and control.
4. Chairperson of the committee supervises epidemiological investigations.
5. Infection Control Nurse shall prepare the committee agenda, surveillance reports and review minutes before approval.
6. Microbiologist shall provide annual antibiogram and report unusual pathogens and isolates.

VII. PROCEDURES FOR INFECTION CONTROL COMMITTEE:

A. The interdisciplinary committee shall:

1. Meet quarterly or more often as needed.
2. Approve an annual surveillance by objectives plan and risk assessment.
3. Review relevant microbiological reports.
4. Review reports of patient infections, as appropriate, to determine whether an infection is a healthcare associated infection using definitions and criteria approved by the committee.

5. Review surveillance data, individual records, and trends for epidemics, clusters of infections, infections due to unusual pathogens, or any occurrence of healthcare associated infections that exceeds our baseline levels.
6. Approve actions to prevent or control infection, based on an evaluation of surveillance reports of infections and of the infection potential among Veterans and hospital personnel.
7. Review proposals and protocols for all specific infection control studies. Recommendations and conclusions resulting from the data and studies will be incorporated into the committee minutes and will be sent to the Clinical Executive Board for review and appropriate action.
8. After reviewing the surveillance data, the committee may refer cases where there is a question of inappropriate antibiotic order to the service chief for study and report back to this committee.
9. The Occupational Health Nurse (OHN) and ~~ICN~~ Infection Control Coordinator communicate and coordinate on employee health issues - i.e.; post-exposure protocol for needlestick injuries, PPD and fit-testing, possible cases of scabies and any related matters (list is not all-inclusive).
10. Minutes are presented at the other leadership committees: EOCB and CEB for implementation of performance improvement activities as recommended.
11. Minutes are forwarded to the Director, Chief of Staff (C.O.S.), Associate Director of Patient Care Services, Quality Manager, Nursing Administration, to all committee members, and staff physicians.
12. Responsibility for taking action on the recommendations documented in the minutes is assigned and defined in writing.
13. Committee shall oversee the implementation of all JC, VACO, CDC, and OSHA standards (related to infection issues) and updates as mandated.

VIII. SURVEILLANCE PLAN: The purpose of the plan is to monitor for early identification of healthcare associated infections in order to develop interventions that would prevent similar infections in other Veterans, visitors and healthcare workers. Surveillance activities are directed by the annual Infection Control Risk Assessment. Current Centers for Disease Control (CDC) and NHSN (National

Healthcare Safety Network) definitions are used for the uniform identification of healthcare associated infections, and a mechanism whereby medical center health care workers report infections to the Infection Control Coordinator. All physicians, Physician Assistants (PAs), Nurse Practitioners (NPs) and nurses are responsible to notify the ICN of infections. The Infection Control Plan is evaluated at a minimum of annually through the annual infection control functional review.

IX. LEGIONELLA

1. Communication of validation activities and results

A. *Legionella* prevention and control in the healthcare setting is multidisciplinary; effective prevention of healthcare associated *Legionella* disease (HCA LD) requires timely communication among staff. This is especially important regarding interpretation of a HCA LD, which will be determined by Infection Control using evidence based guidelines. Follow-up for positive validation results as delineated below. Positive results in one-section trigger further actions, some of which may affect actions required in other sections.

B. If the results of the environmental validation are positive for *L. pneumophila*, the following must be promptly notified: Chief of Staff, the Associate Director for Patient Care Services, the Facility Water Safety Committee, Infection Prevention and Control, and Facility Chief Engineer or Facility Manager. The Chief of Staff and the Associate Director for Patient Care Services are responsible for ensuring that clinicians involved in direct patient care are notified of the positive environmental results, including the species and serogroup detected (if appropriate), in order to implement heightened awareness for clinical testing for LD.

C. If there is a definite or possible HCA LD case at the facility, Infection Prevention and Control is to promptly notify the Chief of Staff, the Associate Director for Patient Care Services, and the Facility Water Safety Committee. This notification of the Facility Water Safety Committee will initiate their review of engineering controls and implementation of the emergency remediation process. Please refer to attachment D.

X. REFERENCES:

Current Joint Commission Accreditation Manual for Hospitals

Scheckler, WE, and all. "Requirements for infrastructure and essential activities of infection control and epidemiology in hospitals: a consensus panel report." AJIC 1998; 28:47-60

Nguyen CT, Proctor SE, Sinkowitz-Cochran RI, Garrett DO, Jariviswix. "Status of Infection Surveillance and Control Projects in the United States 1992-1996" Association for Professionals in Infection Control & Epidemiology Inc. American Journal of Infection Control 2000

Infectious Diseases, Infection Control, and Epidemiology, M-2, Part VI, Chapter 7 (1994)

VHA Directive 2014-1061. Prevention of Healthcare-Associated Legionella Disease and Scald Injury from Potable Water Distribution Systems

XI. RESCISSIONS: MCM 11-21 dated July 2014

/s/

Stephanie Young

Acting Director

Attachments

Preparing Official: Infection Control Nurse

ATTACHMENT A

MULTIDRUG RESISTANT ORGANISM (MDRO) PREVENTION INITIATIVE

- I. In an effort to decrease health care associated complications, the National Infectious Disease Service introduced the Methicillin-Resistant Staphylococcus Aureus (MRSA) Prevention Initiative and the Prevention of Clostridium difficile Infection (CDI) Initiative in Veterans Health Administration (VHA) Acute-Care Facilities. The MDRO Prevention Initiative may also focus on additional MDRO's in the future. The MDRO Prevention Coordinator (MPC) is responsible for the day-to-day management of this program. The MPC works in conjunction with the Infection Control Coordinator. Pertinent findings are reported to the Infection Control Committee whose recommendations are presented to the Clinical Executive Board for approval and action. The Service Chiefs' involvement and commitment in this process, particularly at the clinical level, is very important to further reduce the incidence of hospital acquired infections among Veterans and health care workers.

II. **PURPOSE:**

The purpose of the MDRO Prevention Initiative is to support the VHA Secretary's initiative to decrease health care associated complications.

III. **PROCEDURE:**

All Veterans admitted to the CLC or Acute Care will have a nares culture swab done for all admissions, discharges, transfers (including intraward transfers), authorized absences, any off station appointments, and deaths. Cultures need to be done within 24 hours of admission. All Veterans in the CLC or Acute Care that have a MRSA positive nares swab will be placed in the appropriate indicated precautions. The CDI Initiative requires Veterans that have suspected or confirmed CDI will be placed in contact precautions in the Acute Care or CLC Setting EMS will complete a two- step terminal cleaning process and performs and reports quality assurance data (for more information please reference the Guideline for Prevention CDI in Veterans Health Administration Acute Care Facilities). For discontinuation of precautions, please reference MCM 11-78 Isolation Precautions/Prevention and Management of Infectious and Resistant Organisms.

IV. **RESPONSIBILITIES:**

A. MDRO Prevention Coordinator (MPC):

1. Establish expectations for implementation of MDRO prevention initiatives.

2. Teach and monitor staff compliance with hand hygiene and use of contact precautions.
3. Monitors unit-based data for MDRO prevention and implementation of initiatives for performance improvement.
4. Participate in education, training, conference calls and other activities associated with the MDRO Initiative.
5. Monitor infection/colonization rates.
6. Monitors lab results and posts clinical warnings in the CWAD when a Veteran has a positive nares culture/positive CDI culture.
7. Monitors MRSA nares positive/CDI positive Veterans and removes the CWAD posting when applicable.
8. Is a member of the Infection control Committee (ICC) and reports indirectly to the CEB through the ICC.

B. Infectious Disease Physician:

1. Acts as a consultant to the MDRO Prevention Program.

C. Chief of Staff:

1. Has the overall responsibility for the MDRO Program.

V. REFERENCES:

VHA Directive 2010-006 Methicillin-Resistant Staphylococcus Aureus (MRSA) Prevention Initiative

Guidelines for Implementation of MRSA Prevention Initiative in the Community Living Centers

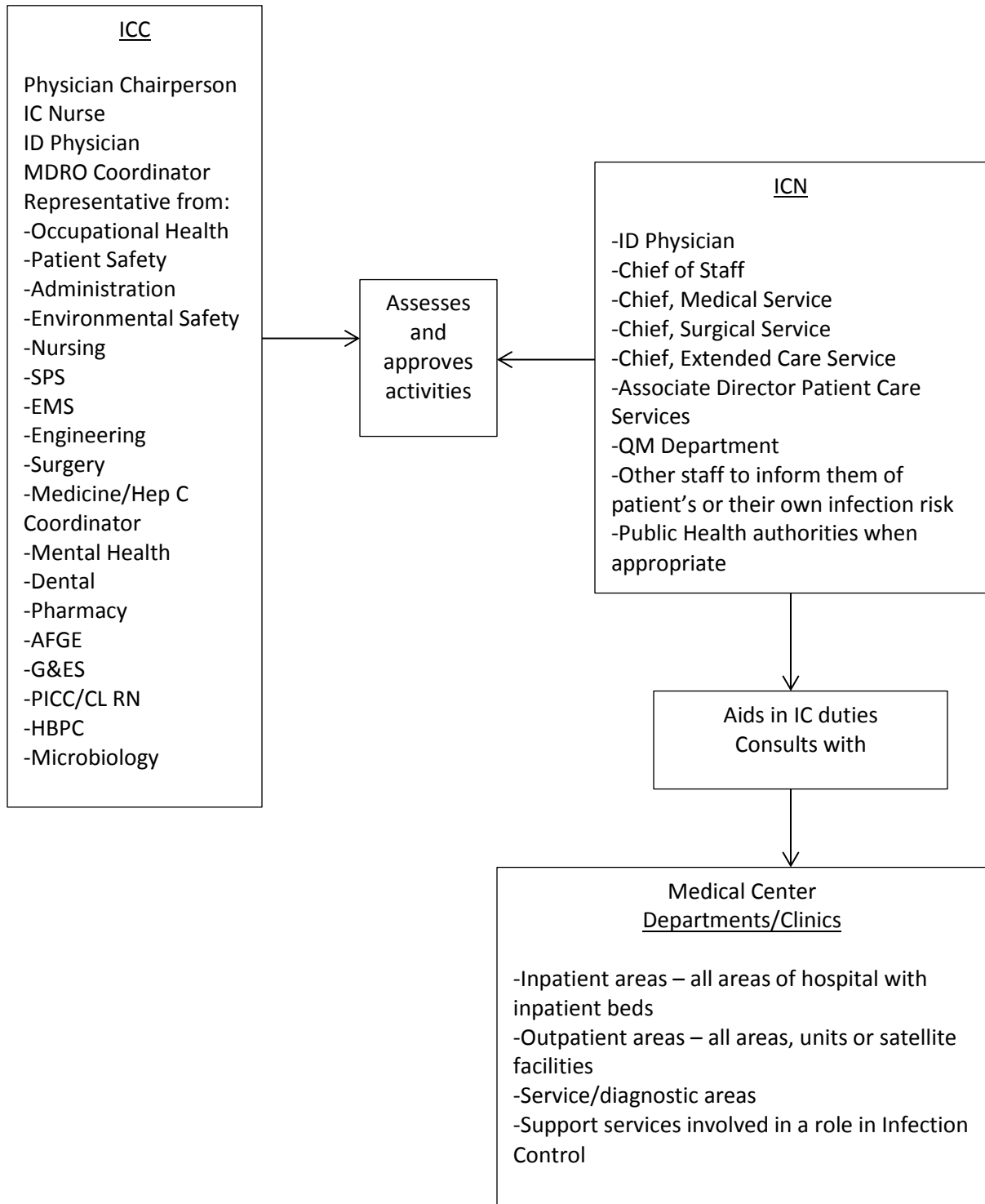
VHA Methicillin-resistant Staphylococcus Aureus (MRSA) Prevention Initiative: Expansion to Outpatient Clinics and Ambulatory Care Settings

Guidelines for Implementation of MRSA Prevention Initiative in VHA Mental Health In-patient Units

Guideline for Prevention of Clostridium difficile Infection (CDI) in Veterans Health Administration (VHA) Acute-Care Facilities (VAIQ # 7210267)

ATTACHMENT B

INFECTION CONTROL PROGRAM



ATTACHMENT C

Surveillance, Prevention, and Control of Infection Function

SURVEILLANCE

A. ANALYSIS

- a) by pathogen
- b) by units or wards
- c) by practitioners
- d) by technology

B. REPORTING

- a) to units or wards
- b) to departments
- c) to practitioners
- d) to infection Control Committee

C. PREVENTION

- a) Environment:
 - 1) Policies and Procedures
 - 2) Operations of Equipment
 - 3) Laboratories
- b) Patient Assessment:
 - 1) Patient high risk?
 - 2) Active infection?
 - 3) Conduct test?
- c) Clinical Practice:
 - 1) Policies and Procedures
 - 2) Adequate Staffing
 - 3) Staff Performance
 - 4) Continuing Education
- d) Propensity for Action
- e) Prerequisite Structure

D. CONTROL

- a) Policies and Procedures for Care

- b) Educational Activities
- c) Authority of IC Staff
- d) Program Direction and Guidance

E. IDENTIFICATION

- a) Case Confirmation:
 - 1) Adequate staffing
 - 2) Direct patient observation
 - 3) Review of labs and x-rays
 - 4) Review of patient chart
 - 5) Communication with staff
- b) Case Finding:
 - 1) Adequate staffing
 - 2) Adequate training
 - 3) Direct patient observation
 - 4) Review of labs and x-rays
 - 5) Review of patient chart
 - 6) Communication with staff
 - 7) Use of written definitions

